



IN THE  
**Supreme Court of the United States**

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October Term, 1977.

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**No. 77-891.**

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**FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. EMMETT FITZPATRICK,**  
*Appellants,*

v.

**JOHN FRANKLIN, M.D. and  
OBSTETRICAL SOCIETY OF PHILADELPHIA,**  
*Appellees.*

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**On Appeal From the United States District Court for the  
Eastern District of Pennsylvania.**

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**BRIEF FOR APPELLEES.**

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**COUNTERSTATEMENT OF  
QUESTIONS PRESENTED.**

**I. Was Not the Court Below Correct in Determining That Section 5(a) of the Abortion Control Act Unconstitutionally Restricts the Abortion Decision Prior to Viability?**

**II. Is Not the Terminology "May Be Viable" and the "Technique Which Would Provide the Best Opportunity for the Fetus to Be Aborted Alive" Void for Vagueness?**

**III. Does Not the Requirement That No Abortions Be Performed When the Fetus "May Be Viable" Unless Necessary to Preserve the Woman's Life or Health Unconstitutionally Restrict a Couple's Right to Conceive and Bear Their Own Biological Children?**

## COUNTERSTATEMENT OF THE CASE.

### I. Introduction.

This is an appeal from the decision of a 3-judge court in the Eastern District of Pennsylvania, holding that Section 5(a) of the Pennsylvania Abortion Control Act, Act No. 209 of 1974, 35 P. S. § 6601 *et seq.*, 6605 ("the Act"), is unconstitutional and enjoining defendants, their agents, employees, successors in interest, and all others acting in concert with them, from enforcing that section. *Planned Parenthood Association, et al. v. F. Emmett Fitzpatrick, Jr. and Frank S. Beal*, No. 74-2440 (September 16, 1977). (239a-244a)

Appellants are Frank S. Beal, Secretary of Welfare of the Commonwealth of Pennsylvania; Robert P. Kane, Attorney General of the Commonwealth of Pennsylvania; The Commonwealth of Pennsylvania; and F. Emmett Fitzpatrick, formerly District Attorney of Philadelphia.

Appellees are John Franklin, M.D., a Board-certified obstetrician and gynecologist and the Obstetrical Society of Philadelphia, a voluntary association of Board-certified obstetricians and gynecologists.

### A. Procedural History.

This case arose out of Appellees' successful challenge to the constitutionality of numerous provisions of the Pennsylvania Abortion Control Act, known as Senate Bill No. 1318, Session of 1973. This Act was passed by the Legislature of Pennsylvania over Governor Shapp's veto and was expressed to be effective October 10, 1975.

On September 20, 1974, Appellees and others filed a Complaint challenging the Act.<sup>1</sup> The plaintiffs included Planned Parenthood Association of Southeastern Pennsyl-

1. The Complaint was subsequently amended on October 3, 1974 and December 10, 1974.

vania, Inc., a non-profit corporation which provides family planning services, and John Franklin, M.D., a Board-certified obstetrician and gynecologist who is the Medical Director of Planned Parenthood. Dr. Franklin performs abortions and counsels patients with regard to family planning.<sup>2</sup> The defendants were F. Emmett Fitzpatrick, Jr., then District Attorney of Philadelphia County and Helen Wohlgemuth, then Secretary of Welfare of the Commonwealth of Pennsylvania.<sup>3</sup>

A three-judge District Court was convened on September 12, 1974.

On October 10, 1974, in response to Plaintiff's Motion for a preliminary injunction, the three-judge Court restrained the enforcement of various provisions of the Act, including Section 5(a).

Following discovery and class action certification, the final hearing on the merits was held from January 13, 1975 through January 17, 1975.

Extensive expert medical testimony was presented by both sides.

On September 4, 1975, the court declared the Act severable and held the following sections unconstitutional:

- Section 2's definition of "viable";
- Section 3(b)(i) and 3(b)(ii);
- Section 5(a);
- Section 6(b);
- Section 6(f); and
- Section 7.

2. The Obstetrical Society of Philadelphia, designated an Appellee herein, was granted leave to intervene as a plaintiff on October 9, 1974.

3. Frank S. Beal replaced Ms. Wohlgemuth in that position during the course of the litigation. He is designated as one of the Appellants herein.

The Attorney General of Pennsylvania and the Commonwealth of Pennsylvania, also designated as Appellants herein, intervened following the final hearing.

Defendants were enjoined from enforcement of those sections. (238a) *Planned Parenthood Association v. Fitzpatrick*, 401 F. Supp. 554 (E. D. Pa. 1975; 3-judge court).

Both parties appealed to the Supreme Court of the United States, *Beal, Secretary of Welfare v. John Franklin, et al.*, No. 75-709 (October Term, 1975); *Franklin, et al. v. Fitzpatrick, District Attorney of Philadelphia, et al.*, No. 75-772 (October Term, 1975), which vacated the judgment and remanded

"for further consideration in light of *Planned Parenthood of Central Missouri v. Danforth*, 428 U. S. — (1976); *Singleton v. Wulff*, 428 U. S. — (1976) and *Virginia State Board of Pharmacy v. Virginia Citizen's Consumer Council*, 425 U. S. — (1976)." (240a) 428 U. S. 901 (1976).

All of the remanded issues except Section 5(a) and Section 7<sup>4</sup> were resolved by stipulation of counsel.

On September 16, 1977, after reconsideration of Section 5(a), the court

"adhere[d] to [its] original view and decision that section 5(a) is unconstitutional." (241a)

Appellants thereupon filed the present appeal, seeking a reversal of the three-judge court's decision.

#### B. Summary of Testimony Pertaining to Section 5(a).

Medical testimony in the court below established that it is impossible to determine whether a particular fetus is viable while it is still in the womb well into pregnancy. (6a-7a; 19a; 43a-44a; 71a-80a; 93a-101a; 111a-112a; 120a-123a; 137a-138a; 141a-142a)

4. Section 7 concerns government subsidy of abortion. It is not challenged in the present appeal.

There is no direct test for determining viability. Physicians rely upon the woman's often inaccurate report of her menstrual history (96a-97a) and an external examination. (94a) Maternal health and nutrition, race, sex, and the facilities of the hospital are also taken into consideration. (78a; 100a-101a; 112a)

As Dr. Louis Gerstley testified upon behalf of Appellees, there are too many variables involved to enable more than a "rough" estimation of viability. (6a)

Appellants' witness Dr. William J. Keenan confirmed that it is a "soft" determination. (121a)

Moreover, physicians disagree as to the gestational age at which viability occurs. Drs. John Franklin and Louis Gerstley, both Board-certified obstetricians and gynecologists, testified upon behalf of Appellees. Dr. Franklin placed viability at about 28 weeks (20a), based upon a 10% chance of survival at that time. (180a) However, he noted that other physicians, particularly neonatologists, who specialize in caring for immature fetuses (31a), might consider a 21-week fetus viable. (29a)

Although Dr. Franklin has sent immature fetuses to a neonatologist, to his knowledge, none have survived. (34a) He theorized that attempts to prolong life at the 20-to-30-week gestational area might result in "artificial viability". (21a)

Dr. Gerstley had a different interpretation of the statutory language. He thought a 24-week fetus had a "reasonable chance of survival", which he defined as somewhere between two and five percent. (8a-9a) He further noted that it is increasingly difficult to determine gestational age as the stage of pregnancy advances. (10a)

Both Drs. Franklin and Gerstley feared that their determination of non-viability might be challenged in a subsequent criminal prosecution. (29a; 30a-31a; 16a) As Dr. Gerstley put it, the statutory language

"leaves the interpretation of 'viability' up to whoever is interpreting the term 'viability' . . . be that the physician or the prosecuting district attorney . . . [and] if a district attorney wanted to make a case, he could say that the physician's judgment is not valid." (16a)

Dr. Franklin further noted that the possibility of other physicians testifying in a criminal prosecution that a 21-week fetus was viable would inhibit his conduct. (29a)

Physicians who testified as to the meaning of viability upon behalf of Appellants disagreed with each other as well as with Appellees' witnesses. Dr. William J. Keenan testified that a 28-week fetus would have a 50 to 60% chance of survival. (93a-93a) He placed viability at 26 weeks, based upon a 10 to 30% chance of survival at that time. He thought that a 20 to 26-week fetus "might be viable". (104a-105a)

However, Dr. Keenan defined viability as survival for 28 days after birth. (108a) He did not testify with reference to the statutory definition.

Citing a report in an early edition of an obstetrics textbook, Dr. Fred Mecklenburg testified that a 20-week fetus was viable. (45a) However, Dr. Keenan challenged that testimony as "not reasonable" and stated that "[e]verybody mistrusts that information." (118a)

Although Dr. Thomas W. Hilgers thought that he could make a reasonable determination that a four-and-a-half to five-month old fetus, weighing more than 400 grams, was viable (79a), he emphasized that it was "very difficult" to determine the size of an unborn infant. (80a) Moreover, he stated that it was impossible to determine viability before birth. (77a)

Witnesses for both sides acknowledged that there is a two to four-week margin of error in estimating gestational age (R. 31; 111a-112a), which compounds the uncertainty of determining whether a fetus is viable or may be viable.

The vagueness of the statutory language causes a particular hardship on couples who are carriers of some sixty genetic diseases. Dr. Hope Punnett, an expert on genetic counseling and testing, testified that amniocentesis can be performed during pregnancy to determine whether a fetus is affected with a grave genetic abnormality such as Tay Sachs or Down's Syndrome (Mongolism). (49a-50a) Children affected with Tay Sachs begin deteriorating at six months. By the age of three, they have lost all function and must be institutionalized until their death at the age of seven or eight. (50a)

However, the test cannot be initiated until 16-weeks' gestation (53a), and the results may not be conclusive until late in the second trimester, beyond 20-weeks' gestation. (53a-54a) A 20-week cut-off for abortions would make genetic counseling "very, very difficult", (55a) since

"[o]ne cannot guarantee a family that we will have a result by a magic date. Sometimes this takes six weeks to get an answer. One cannot do genetic counseling if you cannot follow it to a logical conclusion". (55a)

Dr. Punnett believed that, if no answer were available at 20 weeks, the family might then abort what would have been a normal and wanted child. (55a)

On the issue of abortion methods, there was no medical consensus as to which technique

"would provide the best opportunity for the fetus to be aborted alive." § 5(a)

Dr. Hilgers testified that the best method of preserving fetal life and health was to keep the fetus in the

mother's womb. (75a; 82a) He noted that 15 to 17% of premature infants are affected by motor and mental retardation (73a-75a); and that it would, therefore, be a "great disservice" to deliberately deliver an infant prematurely. (82a)

If a late abortion were to be performed, Dr. Hilgers suggested using prostaglandins. (80a-81a) However, that technique was relatively new at the time of the hearing in the court below. None of the physicians stated that they had ever used it; and Drs. Hilgers, Franklin and Gerstley stated that they had not. (72a; 27a; 83a-84a) Moreover, Dr. Gerstley noted that prostaglandins causes side effects (11a) such as nausea, vomiting, headaches and diarrhea. (38a) In addition, repeated injections are frequently required. (11a)

Although Dr. Gerstley preferred saline for late abortions (11a), saline is unlikely to result in a live birth. (12a) If forced to deliver a 26-week fetus alive, he would use oxytosin induction. (12a) However, forcing oxytosin to work at that stage would be a prolonged and expensive procedure for the woman. (12a) Dr. Franklin confirmed that oxytosin was difficult and might take several days. (27a)

Dr. Mecklenburg thought that the statute required a hysterotomy, which is similar to a Caesarian section. (40a) However, Dr. Hilgers testified that hysterotomies have the highest mortality rate of all the procedures. (73a) Infection and hemorrhage occur in 35 to 45% of the cases. (73a) Although Dr. Franklin did not think that hysterotomies were life-threatening to the woman, he acknowledged that he had never performed any. (29a)

Dr. Gerstley pointed out that, once a hysterotomy has been performed, all future children may have to be delivered by Caesarian section. (13a)

### SUMMARY OF ARGUMENT.

In accordance with *Roe v. Wade*, 410 U. S. 113 (1973), a state may not regulate the abortion decision in the interest of fetal life prior to viability. By imposing a standard of care toward the fetus during the period of "potential viability", section 5(a) unconstitutionally restricts the woman's fundamental right to terminate her pregnancy prior to viability without regard to the state's interest in fetal life.

Furthermore, section 5(a) fails to adequately inform a physician when his duty toward the fetus arises. The physician risks criminal penalties if he aborts a "may be viable" fetus and fails to use the abortion technique which would be most likely to result in a live birth. However, the statute does not specify when a fetus "may be viable" or which abortion technique would satisfy the statutory standard. Disagreement among physicians as to the time of potential viability and the abortion method required demonstrates the vagueness of the statutory language.

Moreover, the physician's good faith determination is not conclusive. Since the physician cannot know, prior to performing an abortion, whether a fetus is viable and whether his judgment that it is not will be challenged in a subsequent criminal prosecution, he will understandably choose to err on the side of caution and refuse to perform an abortion whenever he has some question as to whether a particular fetus may be viable. As a result, women will be deprived of their fundamental right to terminate their pregnancy late in the second trimester.

For example, couples affected by certain genetic conditions may be deprived of the right to conceive and bear their own biological children. Although amniocentesis can be done to determine if a fetus is affected with a serious

and fatal genetic disease, the test results may not be known until late in the second trimester. At that point, a physician might refuse to take the risk that the fetus is not viable and, therefore, refuse to perform the abortion.

## ARGUMENT.

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### I. Section 5(a) Unconstitutionally Restricts the Abortion Decision in the Interest of Fetal Life Prior to Viability; the Provision Is Overbroad.

Statutes which restrict the exercise of fundamental rights must be narrowly drawn to meet a compelling state interest. *Roe v. Wade*, 410 U. S. 113 (1973); *Doe v. Bolton*, 410 U. S. 179 (1973); *Griswold v. Connecticut*, 381 U. S. 479, 485 (1965); *NAACP v. Alabama*, 377 U. S. 288, 307 (1964). The legislation must be "necessary and not merely rationally related to the accomplishment of a permissible state policy." *McLaughlin v. Florida*, 379 U. S. 184, 196 (1964).

*Roe v. Wade*, 410 U. S. 113, 153, 155 (1973) established that the fundamental right of personal privacy is "broad enough to cover the abortion decision." As Mr. Justice Blackmun recognized:

"The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon a woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise to care for it. In other cases . . . the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation." 410 U. S. at 153.

Since the pregnant woman has a fundamental right to terminate her pregnancy, the State may not limit her decision absent a *compelling* State interest.

In *Roe*, the Supreme Court recognized that the State has legitimate interests in maternal health and in protecting the potentiality of human life. Each of those interests becomes compelling at some point during the pregnancy; but, until that point is reached, the State may not, in furtherance of its interests in maternal health or fetal life, unduly restrict the woman's decision to abort,

"the abortion decision in all its aspects is inherently and primarily, a medical decision, and basic responsibility for it must rest with the physician. *Roe v. Wade, supra*, at 166.

Restrictions which impinge upon the physician's medical judgment prior to the inception of a "compelling" state interest, violate both the pregnant woman's fundamental right to determine, in consultation with her attending physician, whether to obtain an abortion and the attending physician's right to freely practice the profession of his choice. *Roe v. Wade, supra*; *Young Women's Christian Association of Princeton, N. J. v. Kugler*, 342 F. Supp. 1048 (D. N. J. 1972; 3-judge court), *vacated and remanded*, 475 F. 2d 1398, *affd.*, 493 F. 2d 1402 (3rd Cir.), *cert. denied*, 415 U. S. 989 (1974). Consequently, such restrictions have been stricken. See, e.g., *Doe v. Mundy*, 378 F. Supp. 731 (E. D. Wisc. 1974), *stay denied*, 419 U. S. 813, *affd.*, 514 F. 2d 1179 (7th Cir. 1975) (hospital may not prohibit performance of elective abortions); *Hodgson v. Anderson*, 378 F. Supp. 1008 (D. Minn. 1974; 3-judge court), *appeal dismissed sub nom. Spannus v. Hodgson*, 420 U. S. 903 (1975) (rules and regulations for abortion

and abortion facilities); *Nyberg v. City of Virginia*, 495 F. 2d 1342 (8th Cir.), *appeal dismissed*, 419 U. S. 891 (1974) (hospital must make its facilities available for performance of abortions); *Doe v. Rampton*, 366 F. Supp. 189 (D. Utah; 3-judge court), *vacated and remanded*, 410 U. S. 950 (1973) (medical reasons for abortion; concurrence of two consulting physicians; spousal and parental consent; judicial hearing).

The State's interest in potential life is not "compelling" until "viability". *Roe v. Wade, supra*, at 163. Viability is described as the point at which the fetus is

"potentially able to live outside the mother's womb, albeit with artificial aid,"

which

"is usually placed at about seven months (28 weeks) but may occur earlier even at 24 weeks."<sup>5</sup> *Roe v. Wade, supra*, at 160.

Section 5(a) of the Pennsylvania Abortion Control Act —in disregard of this Court's dictates in *Roe v. Wade* — seeks to regulate in the interest of fetal life prior to viability by imposing a duty of care toward a "may be viable" fetus. Accordingly, Section 5(a) is overbroad, and the decision of the three-judge court below invalidating that provision, (184a, 238a), should be affirmed.

As Judge Green reasoned in the Opinion below:

"*Roe* recognizes only two periods concerning fetuses. The period prior to viability when the state may not regulate in the interest of fetal life, and the period

5. The latest edition of the medical text cited by the Court as authority for its description of "viability" no longer defines viability as 28 weeks' gestation. The authors note that viability is difficult to define. J. Pritchard and P. McDonald, *Williams Obstetrics*, 483 (15th ed. 1976).

after viability, when it may prohibit altogether or regulate as it sees fit. The 'may be viable' provision of Section 5(a) tends to carve out a third period of time of potential viability. Defendants' witness, Dr. Keenan, testified that based upon his interpretation of Act 209, the Act's definition of potential viability occurs at 20 to 26 weeks gestation. (See Tr. 1/17/75, p. 549.) It is clear that in carving out this new time period labelled 'may be viable' the state is regulating abortions during the second trimester, when it may lawfully do so only in the interest of maternal health . . . [T]he State seeks to justify this provision only as a measure in furtherance of its claimed interest in protecting potentially viable fetuses. Since this provision does not meet the requirements of *Roe*, we declare it to be unconstitutional." (184a)

Your Honorable Court recently reaffirmed the holding in *Roe v. Wade*, *supra*, in a decision which is directly on point to the present case. In *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U. S. 52 (1976), the Court held unconstitutional a Missouri statute which, like Section 5(a) of the Pennsylvania statute, imposed a standard of care toward the fetus prior to viability. That the Missouri duty of care applied during all stages of pregnancy, whereas the Pennsylvania law applies only after the fetus "may be viable" is a distinction without a difference. (See Brief for Appellants, at p. 18, n. 15). The Missouri statute was held unconstitutional because it restricted, in the interest of fetal life, a woman's decision to terminate her pregnancy prior to viability. Since the Pennsylvania provision also seeks to regulate in the interest of fetal life before that interest has become "compelling", it is likewise unconstitutional.

Other courts, considering similar statutes, have agreed. For example, in *Hodgson v. Lawson*, 542 F. 2d 1350 (8th Cir. 1976), the court invalidated as unconstitutionally overbroad a Minnesota statute which prohibited abortion when the fetus was "potentially viable," unless the abortion was necessary to preserve the woman's life or health.

*Wynn v. Scott*, No. 75 C-3975 (E. D. Ill., April 12, 1978), cited by Appellants (at p. 18), does not suggest a contrary result. Unlike the Pennsylvania statute, the duty of care in the Illinois statute was limited to viable fetuses.

Clearly, Section 5(a) is not narrowly drawn to meet a compelling state interest.

By prescribing a duty of care toward a "may be viable" fetus, Section 5(a) "sweep[s] unnecessarily broadly and thereby invade[s] the area of protected freedoms." *Griswold v. Connecticut*, *supra*, at 485, quoting *NAACP v. Alabama*, 377 U. S. 288, 307. As the three-judge court below recognized, the provision is unconstitutional.

## II. Section 5(a) Is Void for Vagueness.

### A. The Terminology "May Be Viable" Fails to Inform the Physician When His Duty Toward the Fetus Arises.

The Due Process Clause of the Fourteenth Amendment requires a state to frame its criminal statutes so that persons may know what conduct is required. *Cline v. Frink Dairy Company*, 274 U. S. 445, 458 (1927). Statutes which fail to provide fair warning to potential offenders or do not set standards to guide courts and juries in determining whether a crime has been committed, violate the due process clause and are void-for-vagueness. Note, "The Void-for-Vagueness Doctrine in the Supreme Court," 109 U. Pa. L. Rev. 67, 68 n. 3 (1960).

As the Supreme Court has stated:

" . . . [A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law." *Connally v. General Const. Company*, 269 U. S. 385, 391 (1926).

See also, *Winters v. New York*, 333 U. S. 507, 515, 518, 520 (1948); *Lanzetta v. New Jersey*, 306 U. S. 451, 453 (1939); *Champlin Ref. Co. v. Commission*, 286 U. S. 210, 242-243 (1932).

Legislation which limits fundamental rights is held to an especially high degree of certainty, lest the imprecision of the statutory language impermissibly "chill" the exercise of those fundamental rights. *Grayned v. City of Rockford*, 408 U. S. 104, 108-109 (1972).

As Mr. Chief Justice Burger stated in his concurring opinion in *Roe v. Wade*, 410 U. S. 113, 208 (1973):

"Of course, states must have broad power, within the limits indicated in the opinions, to regulate the subject of abortions, but where the consequences of state intervention are so severe, uncertainty must be avoided as much as possible."

By imposing a duty of care toward a "may be viable" fetus, Section 5(a) of the Abortion Control Act fails to satisfy this requirement of certainty. Section 5(a), as enforced by Section 5(d)<sup>6</sup>, puts a physician in jeopardy

6. Section 5(a) provides as follows:

"Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and

of criminal sanctions for performing an abortion whenever a fetus "may be viable". From that time of potential viability onward, the physician must use the abortion method most likely to result in a live birth, unless a different method is necessary to preserve the life or health of the pregnant woman.

However, the statute fails to inform the physician when this duty toward the fetus arises. The statute does not specify when potential viability occurs,<sup>7</sup> and there is considerable medical disagreement on that question. (8a-11a; 20a-21a; 30a-33a; 45a; 81a; 92a-93a; 104a-105a; 108a-109a; 116a-118a; 120a; 128a; 129a; 134a; 138a-139a; 143a-144a; 151a-152a)

Interpretations at the hearing in the court below ranged from 28 weeks down to 20 weeks. Dr. Franklin

6. (Cont'd.)

diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother." [Emphasis added.]

Section 5(d) provides, in pertinent part, as follows:

"Any person who fails to make the determination provided for in subsection (a) of this section, or who fails to exercise the degree of professional skill, care and diligence or to provide the abortion technique as provided for in subsection (a) of this section . . . shall be subject to civil or criminal liability as would pertain to him had the fetus been a child who was intended to be born and not aborted."

7. Since the Court did not consider the time frame for "possible viability" in *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U. S. 52 (1976), the comments concerning the legislative definition of viability in that case (see Brief for Appellants at p. 28), do not apply to the vagueness problem in the present case. Section 2 of the Act defines "viability" as having the "capability . . . to live outside the mother's womb albeit with artificial aid". The Act contains no definition of "may be viable."

placed viability at 28 weeks' gestation (20a), based upon a 10% chance of survival at that point. (180a) However, he recognized that other physicians, particularly neonatologists, who specialize in the care of immature fetuses (31a), might consider a 21-week fetus viable. (29a)

Dr. Franklin noted that he has sent immature fetuses to a neonatologist, but, to his knowledge, none have survived. (34a) Attempts to prolong life in the 20-to-30-week gestational period might result in "artificial viability". (21a)

Dr. Gerstley interpreted viability differently. He testified that a 24-week fetus would have a "reasonable chance of survival," on the order of two to five percent. (8a-9a) He noted that the farther along the pregnancy, the harder it is to determine gestational age. (10a)

Dr. Keenan placed viability at 26 weeks, based upon a 10 to 30% chance of survival at that time. (102a) He stated that a 28-week fetus would have a 50-60% chance of survival. (92a-93a) He thought that a 20 to 26-week fetus "may be viable". (104a-105a)

However, Dr. Keenan did not testify with reference to the statutory definition of viability. He defined viability as survival for 28 days after birth. (108a)

Dr. Mecklenburg thought that a 20-week fetus was viable (45a), but Dr. Keenan challenged the data upon which Dr. Mecklenburg relied as "not reasonable" (118a) and not in accordance with current technology. (117a)

While Dr. Hilgers thought he could make a reasonable determination that a four-and-a-half to five-month old fetus, weighing more than 400 grams, was viable (79a), he also thought that it was very difficult to determine the size of an unborn infant. (80a)

Furthermore, all physicians unanimously testified in the court below that it is impossible to determine with

certainty whether a particular fetus is viable while it is still in the womb well into pregnancy. (6a-7a; 19a; 43a-44a; 77a-80a; 93a-101a; 111a-112a; 120a-123a; 137a-138a; 141a-142a) Appellants concede this impossibility. (Brief for Appellants, at p. 26). The most that can be done is to suggest some probability of survival by estimating the period of gestation and applying data relating to survival of fetuses of comparable maturity. (5a-8a; 14a; 19a-21a; 93a-102a)

Among the factors which are considered—none of which can be accurately pinpointed—are the gestational age and the size and weight of the fetus. These factors are "guesstimate[d]" (79a) by the pregnant woman's often inaccurate report of her menstrual history (96a-97a) and an external examination. (94a) Other factors include maternal health and nutrition, which affect both size and probability for survival; race; sex; and the neonatology facilities available in a particular hospital. (78a; 101a; 111a-112a)

There is a two to four week margin of error in estimating gestational age because of the imprecise methods which must be used. (R. 31; 111a-112a)

Despite the impossibility of accurately and objectively determining potential viability prior to an abortion, Section 5(d) imposes criminal sanctions upon a physician who fails to make that determination. Willful or wanton misconduct or even bad faith are not prerequisites to criminal liability. Therefore, even where a physician has determined *in good faith*<sup>8</sup> that a fetus is not viable and has aborted it, there is a very real possibility that the courts will, nevertheless, hold him criminally liable for aborting what other doctors will testify was a viable fetus. (183a)

8. It is undisputed that a physician may not act in bad faith in determining that a fetus is not viable. Appellants' contrary assertion at page 32 of their Brief is unsupportable.

See also, Mr. Justice Douglas dissenting in *United States v. Vuitch*, 402 U. S. 62, 74-75 (1971), on the grounds that the statute did not provide that the physician's determination was conclusive.

Drs. Franklin and Gerstley both expressed their fear of being second-guessed by a court or jury. Reputable physicians, especially neonatologists, might consider a 21-week fetus viable and so testify in a criminal proceeding against another physician. (29a; 30a-31a)

As Dr. Gerstley noted, the statutory language

"leaves the interpretation of 'viability' up to whoever is interpreting the term 'viability' . . . be that the physician or the prosecuting district attorney . . . [and] if a district attorney wanted to make a case, he could say that the physician's judgment is not valid." (16a)

Inevitably, the fear of being second-guessed will inhibit physicians from performing lawful abortions. As a result, women may be deprived of their fundamental right to terminate their pregnancy during the second trimester without regard to the potential for fetal life. (183a); *Roe v. Wade*, 410 U. S. 113 (1973). As Judge Muir stated in invalidating the definition of viability in the same statute which is the subject of the present case:

"A doctor contemplating the performance of an abortion and faced with the definition of 'viability' contained in § 2 is, prior to the operation, unable to determine with assurance whether he will be subject to prosecution if he operates . . . [H]e faces the possibility that there will be a challenge in a later criminal proceeding to the manner in which he made the assessment of non-viability prior to the performance of the abortion. Consequently, the uncertainty intro-

duced by § 2 is likely to lead to a severe curtailment of permissible abortions because of the fear of criminal prosecutions engendered in doctors who are requested to perform them. *Doe v. Zimmerman*, 405 F. Supp. 534, 539 (M. D. Pa. 1975; 3-judge court). (Emphasis added).

Furthermore, the statute provides no standards to guide a court or jury in determining whether a crime has been committed. Consequently, it subjects physicians to the danger of arbitrary and discriminatory prosecution. Such dangers will also inhibit physicians from performing second-trimester abortions. As the three-judge court below recognized:

". . . without an objective standard to guide law enforcement officers, prosecutors and courts, physicians will be subject to prosecution controlled only by the subjective determinations of those charged with law enforcement. The possibility of such arbitrary enforcement certainly will . . . inhibit and deter physicians from performing abortions after a fetus has reached the gestational age of 20 weeks." (183a)

Contrary to Appellants' contentions, the statutory language is not "clear and concise and capable of interpretation by the medical community". (Brief for Appellants, at p. 28)<sup>9</sup>. Nor is it similar to the determination of

9. "May be viable" are "terms involving an appeal to judgment or a question of degree," E. Freund, "The Use of Indefinite Terms in Statutes," 30 *Yale L. J.* 437 (1921), and not "abstractions of common certainty," as Appellants allege at page 29 of their Brief. As Professor Freund recognized, the choice of terms involving an appeal to judgment or a question of degree, the least precise grade of certainty, is more an expression of an inability to deal with a problem than a matter of policy. *Id.*, at 438.

Furthermore, the alleged need for "flexibility of the term," (Brief for Appellants, at p. 26), does not absolve the state of its duty to frame its criminal statutes with precision.

whether an abortion is "necessary for the preservation of the mother's life or health," upheld in *United States v. Vuitch*, 402 U. S. 62, 72 (1971).

A doctor is routinely required, outside the abortion context, to make judgments about his patients' health; and he has numerous objective tests, such as blood tests, x-rays, and EKGs to assist him in making that determination. Only in the abortion context, however, is he subject to criminal liability for his determination of non-viability, a judgment he must make in the absence of any scientific or direct tests.<sup>10</sup>

Clearly, Appellants' contention that "[t]he vagueness argument is set at rest by the decision in *United States v. Vuitch*, 402 U. S. 62, 71-72," (Brief for Appellants at p. 31), is erroneous.

As the three-judge court below held, Section 5(a), as enforced by Section 5(d), is void-for-vagueness.

#### **B. The Statute Fails to Afford Physicians Discretion in Determining Which Abortion Technique Is Appropriate.**

Section 5(a) also fails to adequately inform a physician which abortion method he must use during the late second or third trimester in order to avoid criminal liability.<sup>11</sup> The statute directs him to use that technique which

"would provide the best opportunity for the fetus to be aborted alive, so long as a different technique

10. Amniocentesis can be used to determine the lecithinsphingomyelin ratio, but this ratio does not usually determine viability until about the 34th or 36th week of pregnancy. (7a)

11. Insofar as this requirement applies to the "may be viable" fetus, it impermissibly restricts the abortion decision in the interest of fetal life before that interest has become "compelling." Accordingly, it is unconstitutionally overbroad. See Section I, *supra*.

would not be necessary in order to preserve the life or health of the mother."

Among the methods commonly used for late abortions are saline, prostaglandins, oxytocin induction and hysterotomy.<sup>12</sup> Since saline almost always kills the fetus in utero (36a), Section 5(a) in effect bans the use of saline whenever the fetus is or may be viable, unless that method is necessary to preserve the woman's life or health.

However, as the opinions in *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U. S. 52 (1976) and *Wynn v. Scott*, No. 75 C 3975 (N. D. Ill. April 12, 1978; 3-judge court) recognized, the injection of saline is the method of choice in late abortions. It is safe and effective where the technique is standardized and carried out in a well-equipped institution. D. Sherman, "Salting Out: Experience in 9000 Cases," *J. Reprod. Med.* 14:24 (June 1975; cited by Appellants at page 23).

12. Physicians disagree as to the advisability of dilation and extraction (D&E) for second trimester abortions. Planned Parenthood Federation of America has recognized that this technique is safe for the woman when performed by a skilled physician. Accordingly, Section VII-A of the Manual of Medical Standards and Guidelines prepared by the National Medical Committee of Planned Parenthood Federation of America was revised on or about March 27, 1978, to provide, in pertinent part, as follows:

"Where there are personnel experienced in performing second trimester abortions and adequate facilities and equipment, Planned Parenthood Affiliates may perform abortions up to 16 weeks from the last normal period [14 weeks from conception] by dilatation and evacuation . . . ."

However, some physicians do not favor D&Es after 12 weeks' gestation, because of the danger of perforating the uterus. (39a) The following articles cited by Appellants and written by non-physicians who advocate the use of D&Es as less psychologically traumatic for the woman demonstrate the differences of opinion: "MDs Shun 16th Week D&E as Reminder of Destroyed Fetus," *Medical Tribune*, 9 (January 25, 1978); J. Rooks and W. Cates, Jr., "Emotional Impact of D&E vs. Instillation," *Family Planning Perspectives* 9:276 (Nov.-Dec. 1977).

While any medical procedure is not without complications, Appellants imply that the use of saline presents a medical danger to the woman.<sup>13</sup> For example, at page 23 of their Brief, Appellants cite T. Wagatsuma, "Intra-amniotic Injection of Saline for Therapeutic Abortion," *Am. J. Obst. & Gynec.* 93:743 (November 1, 1965). That article reported on the use of saline in post-war Japan. It emphasized the disastrous and chaotic social conditions in Japan at that time, and the procedures under which saline was used. In many cases, saline was administered by non-specialists under inadequate conditions.<sup>14</sup> Significantly, the Japanese used a 35% saline concentration, whereas a 20% concentration is presently used in the United States. The authorities cited by Appellants in their own Brief state that this difference in saline concentration may have been significant.<sup>15</sup>

Despite the relative safety of saline, Section 5(a) in effect prohibits the physician from using saline under most circumstances.<sup>16</sup> He is left, therefore, with a choice between hysterotomy, prostaglandins or oxytocin induction.

Physicians disagree as to which method would satisfy the statutory requirement. Interpretations at the hearing

13. See S. Lemkin and H. Kattlove, "Maternal Death Due to DIC After Saline Abortion," *Obstet. and Gyn.* 42:233 (August, 1973), cited by Appellants at page 24 of their Brief, reporting what the authors believed was the "only recorded maternal death due to DIC occurring in the course of saline amnioinfusion." *Id.*, at 235.

14. The author believed that most maternal deaths could have been prevented if the procedure had been used by experienced specialists in well equipped institutions, on patients whose general condition had been evaluated carefully.

15. See J. Greenhalf and P. Diggory, "Induction of Therapeutic Abortion by Intra-amniotic Injection of Urea," *Brit. Med. J.* 1:28 (1971), cited by Appellants at page 23 of their Brief.

16. Since saline rarely produces a live birth, it may be used only when necessary to preserve the life and health of the woman.

below ranged from no abortion (75a; 82a), to prostaglandins (80a-81a; 37a), hysterotomy (22a-23a; 26a-29a), or oxytocin induction. (12a) Dr. Hilgers testified that the best method of preserving fetal life and health is to keep the fetus in the mother's womb. (75a; 82a) Premature birth is one of the leading causes of mental and motor retardation. (73a-75a; 81a-82a; 129a) Even if 20-week fetuses were able to survive,<sup>17</sup> approximately 15 to 17% would suffer from mental or motor retardation. (75a) Therefore, any abortion method designed to produce a live birth would, in effect, amount to the intentional infliction of prenatal injury. As Dr. Hilgers stated:

If I am going to risk the premature birth of a child, I am doing a great disservice to that child, and I would not perform this [abortion] procedure as a result of that." (82a)

Nevertheless, when pressed to select an abortion method, Dr. Hilgers chose prostaglandins. (80a-81a) However, at the time of the hearing, none of the physicians who testified stated that they had ever used prostaglandins, and Drs. Hilgers, Franklin and Gerstley stated that they had not. (72a; 27a; 83a-84a) Dr. Gerstley noted his dissatisfaction with prostaglandins because of the side effects it causes. (11a) Among those side effects are nausea, vomiting, headaches and diarrhea. (38a) In addition, prostaglandins are more likely than saline to require repeated injections. (11a) See also, World Health Organization Task Force, "Prostaglandins and Abortions,"

17. Dr. Hilgers identified the survival rate at that age as 20 to 21%. (81a) Dr. Keenan testified that 20-week fetuses do not survive. (91a)

Dr. Franklin testified that any attempts to prolong life in the 20-to-30 week gestational area would in fact merely prolong death. (21a)

*Am. J. Obstet. Gynecol.* 129:597, 599 (November 15, 1977), cited by Appellants at page 22 of their Brief,<sup>18</sup> reporting a "disappointing" although "encouraging" success rate. Abortions were complete in only 31.7% of the 660 patients included in that study. *Id.*, at 598.

Moreover, prostaglandins are medically unsafe for some women. Prostaglandins should not be used on women who have acute pelvic inflammatory disease or are hypersensitive to the drug. It must be used only with caution in patients with a history of asthma, glaucoma, hypertension, cardiovascular disease, or a past history of epilepsy. *Wynn v. Scott, supra*, at 63-64, quoting the description of prostaglandins prepared by the Upjohn Company, which distributes the drug, and approved by the Food and Drug Administration.

For these women, the only remaining methods are oxytosin induction or hysterotomy. Dr. Gerstley recommended oxytosin induction. (12a) However, he doubted whether the procedure would be effective and noted that forcing it to work at that stage would be prolonged and expensive for the patient. (12a) Dr. Franklin confirmed that oxytosin induction was difficult and might take several days, although he stated that he had never used it. (27a)

According to Appellants, hysterotomy is the preferred procedure for inducing live births. (Brief for Appellants, at p. 22). However, Appellants' own witness Dr. Hilgers testified that hysterotomies have the highest mortality rate of all the procedures. (73a)<sup>19</sup> Infection and hemorrhage occur in 35 to 45% of the cases. (73a) Moreover, all future children born to that woman would

18. This article was inadvertently cited in Appellants' Brief as appearing in volume 192.

19. Dr. Franklin's testimony that the risks to the mother's health are not great (29a) merely demonstrates the medical disagreement as to the appropriate abortion technique.

probably have to undergo Caesarian section, because of the danger of rupture of the scar. (13a) Indeed, the Courts in both *Planned Parenthood Association of Central Missouri v. Danforth, supra*, at 76, 79, and *Wynn v. Scott, supra*, at 59-60, concluded that hysterotomy had a significantly greater risk of complications than the other abortion methods and was not, therefore, an adequate substitute for saline amnioinfusion.

Despite the medical disagreement as to which technique "would provide the best opportunity for the fetus to be aborted alive" (§ 5(a)), the statute does not suggest any methods, and there is no assurance that the physician's good faith determination will not be challenged in a subsequent criminal prosecution. (32a-33a) Appellants' contention at page 25 of their Brief that the existence of alternatives and the physician's good faith medical judgment are the only legally relevant considerations cannot save the unconstitutional vagueness of the statutory language. Appellants' interpretation would not be binding upon the district attorneys who may prosecute physicians or the courts and juries which may convict them. It is no substitute for a clear legislative description or a binding judicial interpretation.

Accordingly, the requirement that, whenever the fetus "may be viable", the physician must use the abortion technique "which would provide the best opportunity for the fetus to be aborted alive", violates the Due Process Clause of the Fourteenth Amendment and is void-for-vagueness.

### III. Section 5(a) Unconstitutionally Restricts a Couple's Right to Conceive and Bear Their Own Biological Children.

As already discussed, the vagueness and overbreadth of Section 5(a) unconstitutionally "chill" the pregnant

woman's fundamental right, in consultation with her physician, to terminate her pregnancy during the latter part of the second trimester. As the record in the court below demonstrated, this provision will seriously undermine the opportunity of families with certain genetic characteristics to conceive and bear their own biological children and, in some cases, will result in the abortion of normal and wanted children.

Dr. Hope Punnett, an expert on genetic testing and counseling, testified that where couples have been identified as carriers of some sixty genetic disorders (58a), a test, called amniocentesis, can be performed during pregnancy to determine whether the fetus is affected by the genetic abnormality. If the test results are positive, the fetus may be aborted, thereby saving the parents and the child from the "awful agony of a slow and painful death." (50a)

Amniocentesis requires culturing of cells taken from the amniotic fluid. (50a) The test cannot be initiated with any degree of success prior to the 16th week of gestation, since the uterus is not large enough until that time.<sup>20</sup> If the culture is successful, it takes two to six weeks to be concluded. (53a)

Occasionally, the cells do not grow, but that is not known for a week or ten days. At that point, the obste-

20. Appellants' contention at page 37 of their Brief that "testing for genetic defects or diseases is for the most part completed prior to the attainment of viability by the fetus," (emphasis in original), is erroneous. As Dr. Punnett testified in the court below, it is not feasible to begin amniocentesis until 16-weeks' gestation. (53a) Taps begun at 13 weeks are not successful and must be repeated. (63a-64a) N. Simpson, *et al.*, "Prenatal Diagnosis of Genetic Disease in Canada: Report of a Collaborative Study, *CMA Journal* 115:739 (1976), cited by Appellants at page 39 of their Brief, confirms that success in obtaining amniotic fluid is directly proportional to gestational age, and that the procedure is safe, accurate and reliable when carried out at 16 weeks' gestation.

trician would have to do a second embryotic tap and hope that the cells would then grow. Consequently, positive results could not be obtained until 18 to 20 weeks' gestation at the earliest. (53a)

Tay-Sachs disease and Down's Syndrome (Mongolism) are two of the genetic disorders which can be diagnosed prenatally. Children affected with Tay-Sachs appear normal at birth, but begin deteriorating within six months. By the age of three, they have lost all function and require custodial care until their death at the age of seven or eight. (50a)

Approximately one in every 15 Jews of Eastern European descent is a carrier of Tay-Sachs. The disease is seen in other populations, but it is rarer. (57a) Carriers can be identified by a simple bloodtest.<sup>21</sup> Where a couple are both carriers, there is a 25% chance that each pregnancy will involve Tay-Sachs. (51a)

Genetic counseling provides several options to couples identified as carriers. The couple may (1) proceed with conception without regard to the consequences to the child; (2) prevent conception entirely; (3) accept artificial insemination from a non-carrier donor; or (4) monitor the pregnancy and abort an affected fetus. (51a-52a) Only the latter enables the couple to bear their own biological children without risk.

However, Section 5(a) could prevent a couple from exercising that option. As already mentioned, the results of the amniocentesis may not be known until late in the second trimester, possibly later than 20-weeks' gestation.<sup>22</sup>

21. In the case of Down's syndrome, the propensity for the disease is usually not identified until the birth of the first defective child. Women over the age of 38 have a high risk of having children affected with Down's Syndrome. (50a)

22. Inasmuch as Dr. Punnett is associated with a hospital which does not perform abortions (54a) and which does a very

Faced with a statute which imposes criminal liability upon a physician who aborts a fetus which "may be viable", and armed with the knowledge that physicians disagree as to the point of viability and that the woman's report of her gestational period is very likely inaccurate (96a-97a), a physician may understandably refuse to carry genetic counseling through to its logical conclusion.<sup>23</sup>

Where the test was not conclusive until late in the second trimester of pregnancy,<sup>24</sup> the couple would be deprived of the benefits of the test results which could be obtained and forced to wait out the pregnancy, not knowing whether the child may be "doomed to death" (50a) at a very early age, or abort what may have been a normal and wanted baby. (55a)

Such a result impermissibly infringes upon the fundamental right to bear one's own biological children. *Skinner v. Oklahoma*, 316 U. S. 535, 541-542 (1942). As the three-judge court below concluded, Section 5a is unconstitutional. (177a-185a; 238a)

Appellants' contention at page 42 of their Brief that the decision of the court below is a

"step down the path of genetic or social selections formerly trod by the ancient Spartans, who . . . laid

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22. (Cont'd.)

small number of screenings for Tay-Sachs (57a), her personal observation of only one abortion beyond 20 weeks' gestation does not indicate that such cases are rare, as Appellants seem to imply at page 38, n. 13 of their Brief. (55a)

23. The statute prohibits abortions after viability unless necessary to preserve the woman's life or health. The vagueness of the statutory definition and the potential for criminal sanctions would cause the physician to err on the side of caution and refuse to perform an abortion late in the second trimester of pregnancy.

24. Availability of the test results at that time—which may be the earliest they are obtainable—would be of no avail, unless the doctor determined that the pregnancy endangered the woman's life or health.

the weakest new-born infants on the hillsides of Sparta to die,"

is unsupportable.<sup>25</sup> No one is suggesting that a physician, or anyone else, has any right to destroy a live born child. What we do contend, however, is that before potential life has developed into actual life, the woman, in consultation with her physician, has a constitutional right to decide whether to terminate her pregnancy, and that in making that determination, she is entitled to know whether the fetus is affected with a serious and fatal genetic disease.

Indeed, both the American Medical Association and the American College of Obstetricians and Gynecologists have approved resolutions favoring abortion where

"[t]here is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency." AMA Resolution of June 1967, quoted in C. Kindregan, "Eugenic Abortion," *Suffolk U. L. Rev.*, 3:406, 425 (1972).

See also, Amer. Coll. of Ob. and Gyn., Rptr. H. R. L. § I-A-2, quoted in C. Kindregan, *supra*.

The Model Penal Code has also adopted that position. Model Penal Code § 230.3(2) (Master Edition 1974).

In addition, at least one court has ruled that

". . . [T]he state has less interest in the birth of such a child [with a serious genetic disease] than a woman has in terminating such a pregnancy,"

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25. Equally unsupportable is Appellant's reference at page 42, n. 18, to the psychological impact upon handicapped persons. Section 6(d) directs the physician to use his judgment in making the determination that an abortion is necessary. Appellants unjustifiably denigrate that judgment by implying that the physician would not restrict such therapeutic abortions to cases where the fetus is affected with a grave, incapacitating and fatal genetic disease.

and that

"for the state to deny therapeutic abortion in these cases is an overreaching of the police power." *Abele v. Markle*, 342 F. Supp. 800, 804 (D. Conn. 1972; 3-judge court), *vacated*, 410 U. S. 951 (1973), *reh. denied*, 411 U. S. 940, *on remand*, 369 F. Supp. 807 (D. Conn. 1973; 3-judge court).<sup>26</sup>

See also, *Doe v. Bolton*, 410 U. S. 179 (1973), which invalidated as overly restrictive a Georgia statute in some respects broader than the Pennsylvania statute under consideration in this case. The Georgia statute had permitted abortion when, *inter alia*,

"the fetus would very likely be born with a grave, permanent and irremediable mental or physical defect." 410 U. S. at 183.

The cases cited by Appellants at pages 34 to 36 of their Brief do not support the proposition for which they are cited. *Younger v. Harris*, 401 U. S. 37 (1971), (cited at page 34), concerned federal interference with a pending state criminal prosecution.

*Lamm v. Volpe*, 449 F. 2d 1202 (10th Cir. 1971), *cert. denied*, 405 U. S. 1075 (1972), (cited at page 36), involved federal supremacy. A federal statute required just compensation for the removal of outdoor advertising. The court rejected a state legislator's attempt to bring the removal within the police power, which would have obviated the need for compensation. The court held that the plaintiff lacked standing, and that the case was moot because the state had passed a just compensation statute.

*Wyley v. Warden*, 372 F. 2d 742 (4th Cir.), *cert. denied*, 389 U. S. 863 (1967), cited by Appellants at page

26. On remand in *Abele v. Markle*, *supra*, the three-judge district court reaffirmed its earlier decision that the abortion statute was unconstitutional.

34, is also inapplicable. That case involved a challenge to a state constitutional provision which had been repeatedly upheld by the state courts. Furthermore, the United States Supreme Court had had an opportunity to consider the provision, but had dismissed the appeal for want of a substantial federal question. In addition, the state Constitutional Convention Committee was considering its subcommittee's recommendation that the provision be deleted from the state constitution. Therefore, the court did not want to preempt the state's ongoing political processes.

No fundamental right was involved in the following cases cited by Appellants, so no compelling state interest was required to justify state intervention: *Munn v. Illinois*, 94 U. S. 113 (1876) (economic legislation);<sup>27</sup> *Harrington v. State of Georgia*, 163 U. S. 299 (1896),<sup>28</sup> (running freight trains on Sunday prohibited); *Staten Island Loaders v. Waterfront Commission*, 117 F. Supp. 308 (S. D. N. Y. 1953; 3-judge court), *aff'd.*, 347 U. S. 439 (1954) (public loaders barred from New York piers); *Lincoln Union v. Northwestern Company*, 335 U. S. 525 (1949)<sup>29</sup> (employment not affected by union membership or nonmembership); *Lawton v. Steele*, 152 U. S. 133 (1894) (preservation of fish); *Goldblait v. Town of Hempstead*, 369 U. S. 590 (1962) (excavation for sand

27. In upholding a statute fixing maximum charges for the storage of grain in *Munn v. Illinois*, *supra*, the court noted that similar regulations had been in existence since the days of the Magna Charta. Abortion control statutes, on the other hand, are of relatively recent vintage. *Roe v. Wade*, 410 U. S. 113, 129 (1973).

28. This case was inadvertently cited in Appellants' Brief as *Harrington v. State of Georgia*.

29. This case was inadvertently cited in Appellants' Brief as *State v. Whitaker*. *Whitaker et al. v. North Carolina* was decided in conjunction with *Lincoln Union v. Northwestern Company*, *supra*.

and gravel); *Sweeney v. Murphy*, 39 App. Div. 2d 306, 334 N. Y. S. 2d 239 (1972) (property division fences); *Commonwealth v. Harmar Coal Company*, 452 Pa. 77, 306 A. 2d 308 (1973), *appeal dismissed*, 415 U. S. 903 (1974)<sup>30</sup> (water pollution).

Stricter scrutiny is required where a fundamental right is at stake. As Mr. Justice Goldberg stated in his concurring opinion in *Griswold v. Connecticut*, 381 U. S. 479, 496 (1965):

"While ". . . a . . . State may . . . serve as a laboratory; and try novel social and economic experiments," . . . I do not believe that this includes the power to experiment with the fundamental liberties of its citizens."

Section 5(a) impermissibly interferes with both the woman's right, in consultation with her physician, to terminate her pregnancy, and with the physician's exercise of professional judgment in determining whether a therapeutic abortion should be performed.<sup>31</sup> Accordingly, the provision is unconstitutional, and the decision of the three-judge court below should be affirmed.

30. This case was erroneously cited in Appellants' Brief as *Commonwealth v. Harmon Coal Company*.

31. Although this section has assumed for the purpose of argument, that a fetus affected with a fatal genetic disease could be "viable", an alternative approach is possible. By describing viability in *Roe v. Wade*, *supra*, at 163, as the point at which the fetus "has the capability of *meaningful* life outside the mother's womb," (emphasis added), the Court arguably recognized that therapeutic abortions are permitted where the fetus is affected with a grave, permanent and fatal genetic defect. A child doomed to lose all function and become a vegetable by the age of three and to die by the age of seven or eight (50a) is hardly capable of "meaningful life." It is not, therefore, ever "viable" in the sense in which that term was used in *Roe v. Wade*, *supra*.

## CONCLUSION.

For the reasons set forth above, we respectfully request Your Honorable Court to affirm the Judgment of the three-judge court below holding Section 5(a) of the Abortion Control Act unconstitutional and enjoining Appellants, their agents, employees, successors in interest, and all others acting in concert with them, from enforcing that section.<sup>32</sup>

Respectfully submitted,

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32. Appellants' request at page 43 of their Brief that Your Honorable Court delete the "or may be viable" language from section 5(a) improperly asks this Court to engage in judicial law-making.

It is the duty of the legislature to draft a statute which will withstand constitutional scrutiny. When the legislature has failed to do so, the provision must be stricken. This Court cannot rewrite the statute to save its constitutionality. *Yu Cong Eng v. Trinidad*, 271 U. S. 500 (1926). See also, *Blount v. Rizzi*, 400 U. S. 410, 419 (1971); *Dunne v. United States*, 138 F. 2d 137 (8th Cir.), *cert. denied*, 320 U. S. 790, *reh. denied*, 320 U. S. 814 (1943), *reh. denied*, 320 U. S. 815 (1944).